TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
COMPLIANCE TOXICOLOGY, LLC

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-0984-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a corrective claim on July 11, 2016 which also consisted of two pages. Based on the EOB denial on 8/10/16 only page one of this claim was processed.

Mr. Ball indicates the second bill received by Texas Mutual on 9/7/16 had a new code which constituted a new bill, however, this CPT code was on the original claim which was returned, the corrective claim, and the request for reconsideration."

Amount in Dispute: $$2,251.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual denied this billing for no preauthorization and the documentation did not support the codes billed.

The requestor submitted a second bill for the same date of service and same codes but with an additional code, G0483. . . . This second bill, with the change in codes and billed amount constituted a new bill. Texas Mutual received this bill 9/7/16. This bill was untimely. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 5, 2016	Urinary Drug Screening	$2,251.68	$344.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.200 sets out rules regarding insurance carrier receipt of medical bills.
3. 28 Texas Administrative Code §133.210 sets guidelines for documentation to be sent with medical bills.
4. 28 Texas Administrative Code §134.203 sets out fee guideline for professional medical services.
5. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
6. 28 Texas Administrative Code §137.100 sets out division treatment guidelines
7. Texas Labor Code §401.011 defines words and terms relating to the Texas Workers' Compensation Act.
8. Texas Labor Code §413.017 presumes medical services reasonable if consistent with adopted medical policies.
9. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
   - A04 – DENIED IN ACCORDANCE WITH 134.600(P)(12) TREATMENT/SERVICE IN EXCESS OF DWC TREATMENT GUIDELINES (ODG) PER DISABILITY MANAGEMENT RULES
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERRORS WHICH IS NEEDED FOR ADJUDICATION
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 224 – DUPLICATE CHARGE.
   - 731 – PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.
   - 877 – BILL PREVIOUSLY PROCESSED. REFER TO RULE 133.250 REGARDING REQUEST FOR RECONSIDERATION.

Issues

1. Did the health care provider fail to timely file the bill with the insurance carrier within 95 days of treatment?
2. Was preauthorization of the services required?
3. Did the health care provider fail to send supporting documentation?
4. What is the rule for determining reimbursement for the disputed services?
5. What is the recommended payment for the services in dispute?
6. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with denial reason codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 731 – PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.

   The chronology of the billing submissions and payer actions is summarized here for the purpose of clarity.

   The provider initially submitted a bill that was returned to the provider by the carrier unprocessed with the comment "82055 is not a valid procedure code. Please replace it with a valid and applicable procedure code."

   While it is unclear why the insurance carrier returned the bill to the health care provider—as a carrier may not return a complete medical bill to the provider; and as long as all data fields are complete, a field populated with an invalid code is not an incomplete field. However, the returned bill is not in dispute and will not be further reviewed here.

   The health care provider corrected the code and timely resubmitted the billing on or about June 11, 2016, which (as a result of the corrected code) per division rules constituted a new bill. Review of the submitted information supports by convincing evidence that this corrected bill consisted of two pages, with procedure code G0483 appearing as the sole procedure code on the second page of the claim.

The insurance carrier processed the first six procedure codes from page one of the bill and issued an explanation of benefits. However, the EOB did not address the seventh code billed, G0483, from page two of the claim.

28 Texas Administrative Code §133.200(d) states: "An insurance carrier shall not combine bills submitted in separate envelopes as a single bill or separate single bills spanning several pages submitted in a single envelope."

Based on the submitted information, the division finds that the insurance carrier separated the two pages of the corrected claim (submitted on or about June 11, 2016) and failed to process the charge for procedure code G0483, billed on the second page, with the rest of the services in the claim that were billed on page one. Consequently, the division finds the insurance carrier has failed to meet the requirements of Rule §133.200(d).

The health care provider submitted a request for reconsideration, which the respondent's position statement acknowledges receiving on September 7, 2016. However, the respondent contends that:

> The requestor submitted a second bill for the same date of service and same codes but with an additional code, G0483. . . . This second bill, with the change in codes and billed amount constituted a new bill. Texas Mutual received this bill 9/7/16. This bill was untimely. No payment is due.

The submitted information does not support the respondent's position. Upon review of the documentation, the division finds that the bill contained in the request for reconsideration was identical to the previous (corrected) claim—which was timely submitted on or about June 11, 2016. Both billings contained two pages; the second page contained a single code, G0483—which, although it was present with the billing, was not processed by the insurance carrier on the initial EOB, and was subsequently denied (in error) as a new and untimely code when billed again with the request for reconsideration.

For these reasons the division concludes the insurance carrier's denial reason codes 29 and 731, regarding untimely filing of the bill, are not supported. The initial billing (as corrected) was timely submitted to the insurance carrier, and the request for reconsideration contained the same codes as on the prior submission.

As the insurance carrier has issued no other denial reasons with respect to procedure code G0483, only the fee amount remains in dispute for this code. This service will be reviewed below for payment pursuant to division fee guidelines.

2. The insurance carrier denied disputed services with denial reason codes:

- A04 – DENIED IN ACCORDANCE WITH 134.600(P)(12) TREATMENT/SERVICE IN EXCESS OF DWC TREATMENT GUIDELINES (ODG) PER DISABILITY MANAGEMENT RULES
- 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT

Rule §134.600(c) requires that:

> The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:
> (1) listed in subsection (p) or (q) of this section only when the following situations occur:
> (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
> (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care

The disputed services are diagnostic urinary drug screening tests not directly listed in subsections (p) or (q).

The insurance carrier asserts that the services exceeded DWC treatment guidelines and therefore required preauthorization pursuant to Rule §134.600(p)(12), which concerns treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and not contained in a treatment plan preauthorized by the insurance carrier.

The division treatment guidelines are established in 28 Texas Administrative Code §137.100(a), which states:

> Health care providers shall provide treatment in accordance with the current edition of the Official Disability Guidelines - Treatment in Workers' Comp, excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines)

Review of the patient's medical records with respect to the May 2016 update to the division treatment guidelines finds that drug testing is recommended as an option using a urine drug screen to assess for the use or presence of

illegal drugs. The guidelines further recommend urine drug testing (UDT) as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances.

Review of the submitted information therefore finds that the services billed were within division treatment guidelines appropriate to the date of service and the injured employee's circumstances. Consequently, preauthorization was not required.

The division further finds that the services are presumed reasonable pursuant to 28 Texas Administrative Code §137.100(c), and Labor Code §413.017. The services are also presumed to be "health care reasonably required" as defined by Labor Code §401.011(22-a).

3. The insurance carrier denied payment for disputed services with claim adjustment codes:

   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERRORS WHICH IS NEEDED FOR ADJUDICATION
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.

   And the respondent's position statement maintains that the documentation did not support the codes billed.

   The process for a carrier's request of documentation, not otherwise required by 28 Texas Administrative Code §133.210, is set out in Rule §133.210(d), which requires that:

   > Any request by the insurance carrier for additional documentation to process a medical bill shall:
   > (1) be in writing;
   > (2) be specific to the bill or the bill's related episode of care;
   > (3) describe with specificity the clinical and other information to be included in the response;
   > (4) be relevant and necessary for the resolution of the bill;
   > (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   > (6) indicate the specific reason for which the insurance carrier is requesting the information; and include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

   No documentation was found to support that the carrier made an appropriate request for additional documentation during the billing process with the specificity required by rule. The division thus concludes the insurance carrier failed to meet the requirements of Rule §133.210(d).

   Moreover, upon review of the submitted documentation, the division finds by a preponderance of the evidence that the provider's medical documentation is sufficient to support the services as billed. Accordingly, the division concludes the carrier has failed to support its denial reasons related to documentation.

4. The only remaining issue is the amount of the fees. Accordingly, the disputed services are reviewed for additional payment according to applicable division rules and fee guidelines.

   This dispute regards the technical component of urinary drug screen testing with reimbursement subject to the *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule.

   Rule §134.203(e)(1) specifies that the MAR for laboratory services not addressed in Rule §134.203(c)(1), or other division rules, shall be "125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service."

5. Reimbursement is calculated as follows:

   - Reimbursement for procedure codes 81003, 82542, 82570, 83986, and 84311 are included in the payment(s) for HCPCS codes G0479 and G0483 billed on the same claim. Although the health care provider has listed these codes on the bill, the requestor has not listed these codes on the *Table of Disputed Services* and payment is not in dispute for these. Additional reimbursement for these codes is thus not recommended.
   - HCPCS code G0479 represents a laboratory service with reimbursement determined per Rule §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $60.60. 125% of this amount is $75.75.
   - HCPCS code G0483 represents a laboratory service with reimbursement determined per Rule §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $215.23. 125% of this amount is $269.04.

6. The total allowable reimbursement for the services in dispute is $344.79. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $344.79. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $344.79.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $344.79, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	May 22, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.